Department of Labor and Industries

INTERPRETIVE SERVICES APPOINTMENT RECORD

Use for workers' compensation or crime victim claims.
Send original to insurer. Interpreter: Keep photocopy for your records.

Date of Injury	Claim Number
MM/DD/YY	Y000000

Claimant's phone #	Claimant's name (last, first, middle initial)
(XXX) XXX-XXXX	Doe, John A

APPOINTMENT INFORMATION May be completed by Interpreter or Language Agency

Name of scheduled health care / vocational provider	Appointment date	Start time
Provider's Name (Not clinic name) - James Jones, MD	11/01/08	9:00 AM

Street address of health care / vocational provider	City	State
301 S Main Street	Any City	WA

Type of appointment:
Please check below

X Doctor
❒ PT or OT
❒ Hospital
❒ PCE
❒ Other
❒ Vocational
❒ Pharmacy
❒ Diagnostic
❒ IME

Telephone number: (XXX) XXX-XXXX

Language requested: Russian

Comments

INTERPRETER INFORMATION Completed by Interpreter

Name of interpreter (last, first, middle initial)	Interpreter's Provider Number
Interpreter's Last Name, First Name, Middle Initial	Interpreter's Provider Number - XXXXXX
Language agency's name, if applicable	**Agency's Provider Number**
123 Agency	Agency's Provider Number - XXXXXX

Interpreter's travel starting address	City	State
1245 E. 5th Ave	Any City	WA

Appointment address	City	State
301 S Main Street	Any City	WA

Return or next appointment location	City	State
145 E. 10th Ave	Any City	WA

Mileage to appointment	20
Mileage to next appointment	15
Interpreter's Total Mileage	35

Important: Submit Mileage documentation printout from a software mileage program and name of software program

Group service information
If this was a group service, please indicate number of total persons served in the group and divide service time and mileage accordingly.

Indicate total number of persons served in the group:

Interpreter's arrival time	Scheduled start time	Completion time	Total billable time
8:50 AM	9:00 AM	10:30 AM	Minutes: 90

Date	By signing this document, I certify that I have provided the interpretive services indicated above.
11/01/08	Signature Interpreter's Signature

INTERPRETER SERVICES VERIFICATION

Completed by Health Care of Vocational Provider or their designee.
Do not sign unless information above has been completed.

Comments:

Send original to insurer. Interpreter keep photocopy for your records.

Name of person verifying services (print)	Title
Printed name of person verifying services	Title – Medical Secretary
Signature of person verifying services	**Date**
Signature of person verifying services in provider's office	11/01/08

CLAIM INFORMATION (submit original to insurer) Do not staple documentation to bill forms. Send documentation separately from bills to:

State Fund
Department of Labor and Industries
PO Box 44291
Olympia, WA 98504-4291
1-800-848-0811
360-902-6500
FAX 360-902-4566 360-902-4567
360-902-5230 360-902-6440
360-902-4292 360-902-4565
360-902-6252 360-902-6100

Crime Victim Compensation
Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520
1-800-762-3716
360-902-5377
FAX 360-902-5333

Self-insurer
Varies – Call 360-902-6901 to obtain Insurer's phone number and address
OR
See Self-insurer list at:
http://www.lni.wa.gov/ClaimsIns/Providers/billing/billSIEmp/default.asp

Index: OTH

Instructions for Completing INTERPRETIVE SERVICES APPOINTMENT RECORD

Submit original to the insurer.

Do not staple documentation to bill forms. Use the proper address on bottom of other side to send documentation.

Some Guidelines to complete form.

Claim Number: This is our tracking device. Please ensure the Claim Number of the client is accurate.

Name of scheduled provider: This may be a health care or vocational provider with whom client is scheduled.

Comments: Any special request information or other instructions.

Interpreter Provider Number: Enter the L&I state fund or Crime Victims assigned provider number for the interpreter.

Language Agency Provider number: Enter the L&I state fund or Crime Victims assigned provider number for the language agency.

Mileage to appointment: Calculate the miles from the origins of the trip to the destination. Mileage documentation is required. Documentation must be a printout from a software mileage program and name of software program

Mileage from appointment: This is the return mileage.
Mileage must be split between ALL clients of a group and between clients if there are multiple appointments in one day. If services are delivered in multiple locations for same client, mileage is payable but not the travel time between locations. Only mileage is payable when clients no show at medical or vocational appointments. Mileage documentation is required. Documentation must be a printout from a software mileage program and name of software program

Total billable time: Enter the total billable time (excluding travel time between appointments). Bill from the arrival time or scheduled start time-whichever is LATEST. Interpreter's TRAVEL time is NOT payable.

Group Services: If more than one person was served, please enter the information. Group service time must be divided between ALL clients in the group. After calculating the total mileage and billable time, divide by the total number of clients served in that appointment.

Comments: Please enter any additional information about the services or appointment as needed.

IMPORTANT: Health care or vocational provider or designated staff must sign to verify services.

IMPORTANT: Mileage documentation is required. Documentation must be a printout from a software mileage program and name of software program